MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

510 CERTIFICATE OF DEATH

00492

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 11yrs.2mo.10days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 3701-4 Baltimore
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital
d. STREET ADDRESS: 10 North Anne
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle V. Last ABENDSCHEIN

4. DATE OF DEATH: Month January Day 9 Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-30-93

9. AGE (In years last birthday): 63 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown

10b. KIND OF BUSINESS OR INDUSTRY: unknown

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward Abendschein

14. MOTHER'S MAIDEN NAME: Mary Raider

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Bronchopneumonia, bilateral, unresolved	6-8 days
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Myocardial fibrosis left ventricle, interventricular septum	unknown
DUE TO (c)	Coronary arteriosclerosis	unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis, general, severe - unknown. Tuberculosis, minimal, inactive, right upper lobe - unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): unknown

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year: VA 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 30, 1945, to January 9, 1957 ~~I last saw the deceased alive on~~, and that death occurred at 8:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W Oppler M.D. ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md. DATE SIGNED: 1-10-57

PHYSICIAN'S NAME (Type): W. OPPLER Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 1-10-57

22c. NAME OF CEMETERY OR CREMATORY: Baltimore National

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Pennington & Son, Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: 1-11-57

24b. REGISTRAR'S SIGNATURE: Irene E. Daugherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00493

511 CERTIFICATE OF DEATH

Reg. Dist. No. 96

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit

c. LENGTH OF STAY IN 1b: 72 yrs.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 37 S. Main St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Port Deposit

d. STREET ADDRESS: 37 S. Main St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: C. — Last: Abrahams

4. DATE OF DEATH: Month: 1 — Day: 17 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-23-1879

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Scotland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Cropper

14. MOTHER'S MAIDEN NAME: Jane Emery

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Lewis W. Abrahams, Port Deposit, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocard. Fibs — INTERVAL BETWEEN ONSET AND DEATH: 5 days
422.2
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-13, 1957, to 1-17, 1957, that I last saw the deceased alive on 1-17, 1957, and that death occurred at 8:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: G. H. Richards Jr. M.D. — ADDRESS (Street, city or town, state): Port Deposit, Md — DATE SIGNED: 1-19-57

PHYSICIAN'S NAME (Type): G.H.Richards Jr. M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-21-1957

22c. NAME OF CEMETERY OR CREMATORY: Hopewell

22d. LOCATION (City, town, or county) (State): Port Deposit, Md, Rural

23. FUNERAL DIRECTOR'S SIGNATURE: Vera Patterson & Son — ADDRESS: Perryville, Md.

24a. REC'D BY REGISTRAR DATE: 1-21-57

24b. REGISTRAR'S SIGNATURE: Irene E. Dougherty

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00494 (52)

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
c. LENGTH OF STAY IN 1b: On Road
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 40 and Route 272

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Conn — b. COUNTY: Fairfield
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fairfield 45x-3
d. STREET ADDRESS: 1983 King Highway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Ella	Magoaleha	Baker	Jan.	29	19 57

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
F	W		2-17-1902	54 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cook	Private Res.	Fairfield, Conn	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Ellis	No information

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	045-22-8598	Wallace Baker, 1983 Kings Hihg Fairfield, Conn

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): E Compound Fracture of right frontal — INTERVAL BETWEEN ONSET AND DEATH

816X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): bone with loss of right eye

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a). 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) H it the left side of tractor trailer

20c. TIME OF INJURY Hour	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
8:35 a.m. p.m.	1-29-57		Route 40	North East, Md.	Cecil	Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R. C. Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 1-29-57

EXAMINER'S NAME (Type): R.C.Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Removal	1-29-57	Mountain Grove	Bridgeport Conn

23. FUNERAL DIRECTOR'S SIGNATURE: Henry Tippin — ADDRESS: Elkton, Md

24a. REC'D BY REGISTRAR DATE: 2/1/57 — 24b. REGISTRAR'S SIGNATURE: F R Frazer

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

513 CERTIFICATE OF DEATH

Reg. Dist. No. 00495

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Colora
c. LENGTH OF STAY IN 1b: 67 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Colora

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Annie Middle: Last: Balderston

4. DATE OF DEATH: Month: Jan. Day: 8 Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 11, 1889

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Nurse

10b. KIND OF BUSINESS OR INDUSTRY: Registered Nurse

11. BIRTHPLACE (State or foreign country): Colora, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Balderston

14. MOTHER'S MAIDEN NAME: Myra Atwater

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1st World War

16. SOCIAL SECURITY NO.:

17. INFORMANT: Bertha Balderston Address: Colora, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
DUE TO (b): Cerebral Thrombosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 4 Days / Chronic

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 10, 1956 to Jan 6 1957 that I last saw the deceased alive on Jan 6 1957, and that death occurred at 10:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C. A Benson M.D. ADDRESS (Street, city or town, state): Port Deposit, Md. DATE SIGNED: 1/9/57

PHYSICIAN'S NAME (Type): CLARENCE I. BENSON

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: Jan. 11, 1957

22c. NAME OF CEMETERY OR CREMATORY: Silverbrook Crem.

22d. LOCATION (City, town, or county) (State): Wilmington Del.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Earl Tipton ADDRESS: Rising Sun Md.

24a. REC'D BY REGISTRAR DATE: Jan 14 57

24b. REGISTRAR'S SIGNATURE: Leon M. Wilmington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and signed in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

514 **CERTIFICATE OF DEATH**

Reg. Dist. No. 00496 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 12yrs.4mo.18days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pittsburgh 75x-3
d. STREET ADDRESS: 632 Lowell Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle H. Last CHILDRESS

4. DATE OF DEATH: Month January Day 27 Year 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-20-1889

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jackson Childress

14. MOTHER'S MAIDEN NAME: Willie Scott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia, bilateral, unresolved — INTERVAL BETWEEN ONSET AND DEATH: 3-4 days

420.0

DUE TO (b): Arteriosclerotic heart disease — unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis, general, severe

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September 9, 1944, to January 27, 1956, that I last saw the deceased alive on [illegible], and that death occurred at 8:00 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Oppler M.D.
ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md.
DATE SIGNED: 1-28-57

PHYSICIAN'S NAME (Type): W. OPPLER
Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): removal
22b. DATE THEREOF: 1-28-57
22c. NAME OF CEMETERY OR CREMATORY: Beverly National
22d. LOCATION (City, town, or county) (State): Beverly, New Jersey

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Pennington & Son, Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: 1-30-57
24b. REGISTRAR'S SIGNATURE: Irene E. Daugherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and signed in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

File No. 515

Reg. Dist. No. 00497 97

1. PLACE OF DEATH
a. COUNTY: Cecil
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Harford

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bainbridge, Md.
c. LENGTH OF STAY IN 1b: 1 day

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace 12-24-2

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

d. STREET ADDRESS: 112 S. Union Avenue

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John; Middle: Lawrence; Last: CONCES

4. DATE OF DEATH: Month: 1; Day: 11; Year: 1957

5. SEX: Male

6. COLOR OR RACE: Cauc

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-10-57

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months: Days: 1
IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Bainbridge, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: John Lawrence CONCES

14. MOTHER'S MAIDEN NAME: Patricia Joanne ZYGMUNT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Navy Records
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Suspected Intracranial Hemorrhage
760.0

DUE TO
(b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-10-57, 19 57, to 1-11-57, 19____, that I last saw the deceased alive on 1-11-57, 19____, and that death occurred at 1410 P M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: Peter R. Dallman M.D.

PHYSICIAN'S NAME (Type): PETER R. DALLMAN, LT MC USN, BAINBRIDGE, MARYLAND 1-11-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-12-57

22c. NAME OF CEMETERY OR CREMATORY: West Nottingham Cemetery

22d. LOCATION (City, town, or county) (State): Colora, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Ed Patterson & Son, Perryville, Md.
ADDRESS

24a. REC'D BY REGISTRAR DATE 1-11-57

24b. REGISTRAR'S SIGNATURE: Sheila M Kelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

201/221XV3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

516 CERTIFICATE OF DEATH

00498

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Mary's

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 6yrs.6mo.8days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 18 x 22 Hollywood

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

d. STREET ADDRESS:

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EUGENE Middle I. Last CONNOR

4. DATE OF DEATH: Month January Day 4 Year 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-9-1892

9. AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: unknown

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Bojan Connor

14. MOTHER'S MAIDEN NAME: Nellie (?)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia, unresolved, right lower lobe — INTERVAL BETWEEN ONSET AND DEATH: 7-10 days

420.1

DUE TO (b): Coronary arteriosclerosis severe — unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Arteriosclerosis, general, severe — unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

VA

21. I certify that I attended the deceased from June 27, 1950, to January 4, 1957, that I last saw the deceased alive on [illegible], 19[illegible], and that death occurred at 8:10 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE OF M.D.: W. Oppler — ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md. — DATE SIGNED: 1-4-57

PHYSICIAN'S NAME (Type): W. OPPLER — Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 1-4-57

22c. NAME OF CEMETERY OR CREMATORY: St. Aloysius

22d. LOCATION (City, town, or county) (State): Leonardtown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Pennington & Son, Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: 1-5-57

24b. REGISTRAR'S SIGNATURE: Irene E. Dougherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and signed in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00499

517 **CERTIFICATE OF DEATH**

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit, Rural
c. LENGTH OF STAY IN 1b: Life

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Port Deposit, Rural

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Cokesbury

d. STREET ADDRESS: Cokesbury
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
George	Littleton	Cooper	1	15	1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	Colored		7-19- 1874	82 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Day	Md	USA

13. FATHER'S NAME: William H. Cooper

14. MOTHER'S MAIDEN NAME: Margaret Anne Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No		Martha Bolling, 402 W. Front St., Wilmington, Delaware.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from Nov 24 1956, to Jan 12, 1957, that I last saw the deceased alive on Jan 12, 1957, and that death occurred at 1 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C. T. Pearson M.D. ADDRESS (Street, city or town, state): Port Deposit Md. DATE SIGNED: 1/15/57

PHYSICIAN'S NAME (Type): CLARENCE T. PEARSON

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	1-19-1957	Cokesbury	Port Deposit, Md, Rural

23. FUNERAL DIRECTOR'S SIGNATURE: Vera Patterson & Son ADDRESS: Perryville, Md.

24a. REC'D BY REGISTRAR DATE: 1-17-57

24b. REGISTRAR'S SIGNATURE: Irene E. Daugherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00500 72

495

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 12 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: 108 Hollingworth Manor
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Louise — Middle: Jean — Last: Creswell
4. DATE OF DEATH: Month: Jan. — Day: 25 — Year: 1957
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-9-54
9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: 22 — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Elkton, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George E. Creswell
14. MOTHER'S MAIDEN NAME: Louise Bolton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: ----------
17. INFORMANT: George E Creswell. Address: Elkton. Md. 108 Hollingworth

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	First and Second degre burns of back zzz	
DUE TO (b)	back and right arm .	
DUE TO (c)	Hypostatic Pneumonia.	

917.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Pulled a hot Pot of coffee on herself
20c. TIME OF INJURY: Hour 2 a.m. p.m. — Month, Day, Year: 1-21-57
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town): Elkton (County): Cecil (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Notural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: A.C. Dodson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 1-25-56

EXAMINER'S NAME (Type): R.C. Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Buried
22b. DATE THEREOF: 1/27/57
22c. NAME OF CEMETERY OR CREMATORY: Cherry Hill Methodist
22d. LOCATION (City, town, or county): Cecil (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: H. Walter du Burg Jr. ADDRESS: Elkton, Md.
24a. REC'D BY REGISTRAR DATE: 1/27/57
24b. REGISTRAR'S SIGNATURE: E R Traeger

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5) 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

: 518 **CERTIFICATE OF DEATH**

Reg. Dist. No. 96 00501

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 2 mo. 22 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 2618 University Place, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT — Middle (NMI) — Last CROSBY

4. DATE OF DEATH: Month January — Day 24 — Year 19 57

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-20-91

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ira Crosby

14. MOTHER'S MAIDEN NAME: Eliza (?)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 578 22 7257

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia, right lung, unresolved — INTERVAL BETWEEN ONSET AND DEATH: 4-5 days
600.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Pyelonephritis, bilateral--staphylococcus albus — unknown
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis, general, severe - unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year: VA 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 2, 19 56, to January 24, 19 57, that I last saw the deceased alive on [illegible], 19[illegible], and that death occurred at 4:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md.
DATE SIGNED: 1-25-57

PHYSICIAN'S NAME (Type): W. OPPLER
Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 1-25-57
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: PENNINGTON & SON, Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: 1-25-57
24b. REGISTRAR'S SIGNATURE: Irene E. Dougherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

519

CERTIFICATE OF DEATH

00502 Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Conowingo, Rural
c. LENGTH OF STAY IN 1b: Life
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Conowingo, Rural

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Rowlandville
d. STREET ADDRESS: Rowlandville
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gaylord Middle: Last: Curry
4. DATE OF DEATH: Month: 1 Day: 2 Year: 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-4-1906
9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pipe Fitter
10b. KIND OF BUSINESS OR INDUSTRY: Gen. Construction.
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William C. Curry
14. MOTHER'S MAIDEN NAME: Ella Billingsley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
16. SOCIAL SECURITY NO.: 213-12-5173
17. INFORMANT: Marie Z. Curry, Address: Conowingo, Md. R F D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immed
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/31, 1956, to 1/2, 1957, that I last saw the deceased alive on 12/31, 1956, and that death occurred at 1:25 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Dudley Phillips M.D.
ADDRESS (Street, city or town, state): Darlington Md
DATE SIGNED: 1/3/57

PHYSICIAN'S NAME (Type): Dudley Phillips, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-5-1957
22c. NAME OF CEMETERY OR CREMATORY: Hopewell
22d. LOCATION (City, town, or county) (State): Port Deposit, Md. Rural

23. FUNERAL DIRECTOR'S SIGNATURE: Vera Patterson & Son
ADDRESS: Perryville, Md.
24a. REC'D BY REGISTRAR DATE: 1-3-57
24b. REGISTRAR'S SIGNATURE: Irene E. Daughtry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00503

520

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 1 mo. 7 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12-24-2 Havre de Grace
d. STREET ADDRESS: 833 Juniata Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ENRICO — Middle — Last DI VINCENTIS

4. DATE OF DEATH: Month January — Day 21 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-12-1890

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic(Retired)

10b. KIND OF BUSINESS OR INDUSTRY: Artillery -Aberdeen Proving Ground

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Angelo DiVincentis - Deceased

14. MOTHER'S MAIDEN NAME: Marie Tonnella - Deceased

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Laennec's cirrhosis — INTERVAL BETWEEN ONSET AND DEATH: unknown
581.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic heart disease — unknown
DUE TO
(c) Aortic stenosis due to arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis, general
420.0
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — a. m. / p. m. — Month, Day, Year: VA 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December 14, 1956, to January 21, 1957, that I last saw the deceased alive on ____, and that death occurred at 10:40a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Oppler — M.D.
ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md.
DATE SIGNED: 1-21-57

PHYSICIAN'S NAME (Type): W. OPPLER
Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 1-24-57
22c. NAME OF CEMETERY OR CREMATORY: Mt. Erin
22d. LOCATION (City, town, or county) (State): Havre de Grace, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Pennington & Son, Havre de Grace, Md.

24a. REC'D BY REGISTRAR — DATE: 1-24-57
24b. REGISTRAR'S SIGNATURE: Irene E. Daugherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and signed in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

496 CERTIFICATE OF DEATH

00504

Reg. Dist. No. 92

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton

c. LENGTH OF STAY IN 1b: 23 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ×2 Calvert

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

d. STREET ADDRESS: R. F. D.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Duane; Middle: ; Last: ECCLES

4. DATE OF DEATH: Month: January; Day: 26; Year: 1957

5. SEX: M

6. COLOR OR RACE: Wh.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: March 25, 1867

9. AGE (In years last birthday): 89 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Lumberman

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Eccles

14. MOTHER'S MAIDEN NAME: No Information

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Albert Eccles, Nottingham, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Myocarditid — INTERVAL BETWEEN ONSET AND DEATH

422.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Arteriosclerosis and urinal retention

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED White at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-4-57, 19___, to 1-27, 1957, that I last saw the deceased alive on 1-27, 1957, and that death occurred at 2.30 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: R.C. Dodson M.D.

ADDRESS (Street, city or town, state): Rising Sun, Md.

DATE SIGNED: 1-27-56

PHYSICIAN'S NAME (Type): R.C. Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-29-1957

22c. NAME OF CEMETERY OR CREMATORY: Hopewell Cemetery

22d. LOCATION (City, town, or county) (State): R. D. Port Deposit Md.

23. FUNERAL DIRECTOR'S SIGNATURE: W. Henry Biffin

ADDRESS: 259 E. Main St. Elkton, Md.

24a. REC'D BY REGISTRAR DATE: 1/30/57

24b. REGISTRAR'S SIGNATURE: J R Frazer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG210 1-29-57 et

521

CERTIFICATE OF DEATH

Reg. Dist. No. 00505

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Rising Sun
c. LENGTH OF STAY IN 1b: 3 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Rural-Rising Sun
d. STREET ADDRESS: near-Farmington
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William; Middle:; Last: Edwards

4. DATE OF DEATH: Month: Jan; Day: 19; Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 8, 1906

9. AGE (In years last birthday): 50 Yrs. 5 Mos. 11 Ds.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): N. C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Richard Edwards

14. MOTHER'S MAIDEN NAME: Emma Moxley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 242-14-0473

17. INFORMANT: Pauline Edwards
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebrovascular accident	1 hours
DUE TO (b)	Carcinoma of pancreas.	1 year
DUE TO (c)		

157X

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 19 56 to 1/19, 19 57, that I last saw the deceased alive on 1/19, 19 57, and that death occurred at 9A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Neal Taylor M.D.
ADDRESS (Street, city or town, state): Rising Sun, Md
DATE SIGNED: 1/19/57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/22/57

22c. NAME OF CEMETERY OR CREMATORY: Methodist Church C

22d. LOCATION (City, town, or county) (State): Shiloh, N.C.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Ralph M Reed, Rising Sun, Md

24a. REC'D BY REGISTRAR: Jan 19-57

24b. REGISTRAR'S SIGNATURE: L M Worthington

FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 signed by the hospital or attending physician.
TO DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

522 **CERTIFICATE OF DEATH**

00506

Reg. Dist. No. 96

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md — b. COUNTY: Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville, Rural — c. LENGTH OF STAY IN 1b: 57 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Perryville, Rural
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Aikin	d. STREET ADDRESS: Aikin — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Sallie	J.	Fisher	1	10	19 57

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White		Sept. 8, 1863	93 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife	Own Home	Md	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
NO		Curtis E. Fisher, Rising Sun, Md. Rural

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

422.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Arthritis — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 20, 1956 to Jan 8, 1957, that I last saw the deceased alive on Jan 8, 1957, and that death occurred at 11:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C. I. Benson M.D. — ADDRESS (Street, City or town, state): Port Deposit, Md. — DATE SIGNED: 1/11/57

PHYSICIAN'S NAME (Type): Clarence I. Benson, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	1-12-1957	St. Marks	Perryville, Md. Rural

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Lewis Patterson & Son, Perryville, Md.	1-12-57	Irene E. Dougherty

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

523 CERTIFICATE OF DEATH

Reg. Dist. No. 00507 94

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 1 mo. 10 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: WASHINGTON — b. COUNTY: D C
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 47 X-3
d. STREET ADDRESS: 1451 N Street, NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First GEORGE — Middle FINLEY — Last FRANKLIN

4. DATE OF DEATH: Month January — Day 22 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 25, 1890

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman (retired)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ALBERT FRANKLIN

14. MOTHER'S MAIDEN NAME: MARTHY COFFEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW-I

16. SOCIAL SECURITY NO.: 578-28-9738

17. INFORMANT — Address: Hospital Records, VA Hospital, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Bronchopneumonia, bilateral, unresolved — INTERVAL BETWEEN ONSET AND DEATH: 5 to 6 days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) 2. Pyelonephritis, left — Unknown

DUE TO

(c) 3. Prostatic hypertrophy, benign — Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis, generalized, moderate

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year, Hour a. m. p. m.

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I VA attended the deceased from Dec. 12, 1956, to Jan. 22, 1957, last saw the deceased alive on [illegible], and that death occurred at 8:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Oppler, M.D. — ADDRESS (Street, city or town, state): Perry Point, Maryland — DATE SIGNED: 1-23-57

PHYSICIAN'S NAME (Type): W. OPPLER, M.D., Director, Professional Services, VAH., Perry Point, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): ~~REMOVAL~~ Burial

22b. DATE THEREOF: 1-28-57

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: J. W. Chambers — ADDRESS: 1400 Chapin St. Wash. D.C.

24a. REC'D BY REGISTRAR — DATE: JAN 28 1957

24b. REGISTRAR'S SIGNATURE: Irene Daugherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Items 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

524 — 00508 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun Rural
c. LENGTH OF STAY IN 1b: 4 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO Rising Sun Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mattie — Middle: Esther — Last: Gerhard
4. DATE OF DEATH: Month: 1 — Day: 24 — Year: 19 59

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-14-1913
9. AGE (In years last birthday): 43 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: House work
11. BIRTHPLACE (State or foreign country): Smith Co. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David Powers
14. MOTHER'S MAIDEN NAME: Callie Stocks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 238-34-6685
17. INFORMANT: Address: Charley Gerhard, Rising Sun, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH:
593x
DUE TO (b): Nephritis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 420.1
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒; and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.C. Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 1-24-59
EXAMINER'S NAME (Type): R.C. Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan 27, 1959
22c. NAME OF CEMETERY OR CREMATORY: West Nottingham
22d. LOCATION (City, town, or county) (State): Cecil Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Earl Tyson — ADDRESS: Rising Sun Md
24a. REC'D BY REGISTRAR (DATE): Jan 26-59
24b. REGISTRAR'S SIGNATURE: L M Northington

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

525 — 00509 — Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Elm St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Perryville
d. STREET ADDRESS: Elm St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Susie — Middle: May — Last: Gillespie

4. DATE OF DEATH: Month: 1 — Day: 17 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 1, 1874

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: General Store

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Peter Gillespie

14. MOTHER'S MAIDEN NAME: Amanda Harris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Irene Sentman, Perryville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos
DUE TO
334X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteria Sclerosis — 10 yrs
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Cellulitis left Leg —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 10, 1957, to Jan 17, 1957, that I last saw the deceased alive on Jan 17, 1957, and that death occurred at 3:35 p. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: C. I. Benson M.D. — ADDRESS (Street, city or town, state): Port Deposit, Md — DATE SIGNED: 1/18/57

PHYSICIAN'S NAME (Type): C. I. Benson, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-20-1957
22c. NAME OF CEMETERY OR CREMATORY: Hopewell
22d. LOCATION (City, town, or county) (State): Port Deposit, Md. Rural

23. FUNERAL DIRECTOR'S SIGNATURE: Lee A. Patterson & Son — ADDRESS: Perryville, Md.

24a. REC'D BY REGISTRAR DATE: 1-20-57

24b. REGISTRAR'S SIGNATURE: Irene E. Daughaday

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, post should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

497 CERTIFICATE OF DEATH

Reg. Dist. No. 00510

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: UNION MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WHITE CRYSTAL BEACH, EARLEVILLE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ELLA — Middle: M. — Last: (SPENCE) GREEN

4. DATE OF DEATH: Month: JAN. — Day: 16 — Year: 1957

5. SEX: F. — 6. COLOR OR RACE: W. — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUG. 26, 1906

9. AGE (In years last birthday): 50 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RESORT MANAGER
10b. KIND OF BUSINESS OR INDUSTRY: SUMMER RESORT
11. BIRTHPLACE (State or foreign country): WILM. DEL.
12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: ALFRED GREEN
14. MOTHER'S MAIDEN NAME: ETHEL PEARCY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 222-03-8085
17. INFORMANT: MRS. ETHEL GREEN, Address: EARLEVILLE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 10 min
DUE TO
(b): Cerebral Metastases — 6 mos.
DUE TO
(c): Carcinoma of Breast

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): multiple bone and visceral metastases

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1956, to Jan, 1957, that I last saw the deceased alive on Jan 16, 1957, and that death occurred at 4:45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wallace Oberstein M.D.
ADDRESS (Street, city or town, state): Cecilton Md
DATE SIGNED: 18 Jan 57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 1/19/57
22c. NAME OF CEMETERY OR CREMATORY: CECILTON CEM.
22d. LOCATION (City, town, or county) (State): CECILTON MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Hellows
ADDRESS: Millington, Md.
24a. REC'D BY REGISTRAR DATE: JAN 22 1957
24b. REGISTRAR'S SIGNATURE: L. R. Fragers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

RECEIVED

JAN 22 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

526

CERTIFICATE OF DEATH

00511

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 33yrs.11mo.28days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New Jersey — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chatham
d. STREET ADDRESS: 67X3 3 Chestnut Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle J. — Last GREENE

4. DATE OF DEATH: Month January — Day 3 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-3-93

9. AGE (In years last birthday): 63 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Law

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic coronary heart disease, severe — INTERVAL BETWEEN ONSET AND DEATH: unknown

420.1

DUE TO
(b): Myocardial fibrosis interventricular septum — unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO
(c): Arteriosclerosis, general, severe — unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year: VA 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 6, 19 23, to January 3, 19 57, that I last saw the deceased alive on [illegible], 19[illegible], and that death occurred at 9:30 pM, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Oppler, M.D. — ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md. — DATE SIGNED: 1-4-57

PHYSICIAN'S NAME (Type): W. OPPLER — Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): removal

22b. DATE THEREOF: 1-4-57

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Pennington & Son, Havre de Grace, Md Md.

24a. REC'D BY REGISTRAR — DATE: Jan 8-57

24b. REGISTRAR'S SIGNATURE: Irene E. Daugherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

527

00512 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: RFD #3 Box 4 ELKTON

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
d. STREET ADDRESS: RFD #3 Box 4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First EDNA — Middle B. — Last HAMM
4. DATE OF DEATH: Month JAN. — Day 6 — Year 1957

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DEC. 20 1895
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ROBERT BREEDING
14. MOTHER'S MAIDEN NAME: NO RECORD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 221-05-6885
17. INFORMANT: WALTER J. HAMM Address RFD #3 BOX 4 ELKTON, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Cardiac Dilatation — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Cerebral Hemorrhage — 1 day
DUE TO (c): Cardio Vascular renal — 3 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
442X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov, 1956, to Jan 6, 1957, that I last saw the deceased alive on Jan 6, 1957, and that death occurred at 8 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Herbert Bates — M.D. — ADDRESS (Street, city or town, state): 230 E. main st Elkton Md — DATE SIGNED: 1/7/57
PHYSICIAN'S NAME (Type): J. HERBERT BATES

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 1/10/57
22c. NAME OF CEMETERY OR CREMATORY: NEWARK CEM.
22d. LOCATION (City, town, or county) (State): NEWARK DEL.

23. FUNERAL DIRECTOR'S SIGNATURE: R.T. Jones — ADDRESS: Newark, Del.
24a. REC'D BY REGISTRAR DATE: Jan 11
24b. REGISTRAR'S SIGNATURE: F R Frazer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

RECEIVED

JAN 14 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

528 CERTIFICATE OF DEATH

Reg. Dist. No. 09513

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 3 mo. 13 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22-12-2 Salisbury
d. STREET ADDRESS: 713 Camden Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle C. — Last HARRINGTON

4. DATE OF DEATH: Month January — Day 25 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-3-95

9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frank Harrington

14. MOTHER'S MAIDEN NAME: Isadora Pritchette

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I & WW II

16. SOCIAL SECURITY NO.: 218 12 1630

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Broncho Pneumonia, Bilateral, Unresolved — INTERVAL BETWEEN ONSET AND DEATH: 4 - 5 days

355X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause fost.

(b) Progressive subcortical encephalopathy (Paralysis agitans) — Unknown

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19 — VA

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that ☒ attended the deceased from October 12, 1956, to January 25, 1957, ~~that I last saw the deceased alive on~~, and that death occurred at 1:20 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph C. Grasberger M.D. — ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md. — DATE SIGNED: 1-26-57

PHYSICIAN'S NAME (Type): JOSEPH C. GRASBERGER, M.D., Acting Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): removal

22b. DATE THEREOF: 1-26-57

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hill & Johnson Co., 705 East Main St., Salisbury, Md.

24a. REC'D BY REGISTRAR — DATE: 1-26-57

24b. REGISTRAR'S SIGNATURE: Irene E. Daugherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

529

CERTIFICATE OF DEATH

00514

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point, Maryland
c. LENGTH OF STAY IN 1b: 4 Months 26days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C. 47x-3
d. STREET ADDRESS: 113 33rd Street, N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James; Middle A.; Last Harris

4. DATE OF DEATH: Month 1; Day 26; Year 19 57

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-17-85

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian (Retired)

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George W. Harris (Deceased)

14. MOTHER'S MAIDEN NAME: Ann Kernard (Deceased)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW1 & WW11

16. SOCIAL SECURITY NO.: 216 05 0465

17. INFORMANT Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia, bilateral, unresolved — INTERVAL BETWEEN ONSET AND DEATH: 3-4 days

420.0

DUE TO (b): Arteriosclerotic heart disease, severe. — Unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Arteriosclerosis, generalized, severe. — Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that VA attended the deceased from 8-31, 19 56, to 1-26, 19 57, that I last saw the deceased alive on 19, and that death occurred at 3:10A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph C. Grasberger M.D.
ADDRESS (Street, city or town, state): VAH., Perry Point, Md.
DATE SIGNED: 1-26-57

PHYSICIAN'S NAME (Type): JOSEPH C. GRASBERGER, M.D, Acting Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 1-27-57
22c. NAME OF CEMETERY OR CREMATORY: Baltimore National
22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Mrs Kate L Wilson
ADDRESS

24a. REC'D BY REGISTRAR DATE: 1-27-57
24b. REGISTRAR'S SIGNATURE: Irene E. Daughtry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

530

CERTIFICATE OF DEATH

00515

Reg. Dist. No. 91

1. PLACE OF DEATH
a. COUNTY Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Morgan Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD. b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Katherine Middle V. Lost Howard
4. DATE OF DEATH Month Jan. Day 8 Year 1957
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH June 23, 1866
9. AGE (In years last birthday) 90 yrs.
IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) MD
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME John E. Ferguson
14. MOTHER'S MAIDEN NAME Margaret E. Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. None
17. INFORMANT Harry Budd — Address Cecilton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 3 mos
332x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis — years.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Senility
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug, 1956, to Jan 8, 1957, that I last saw the deceased alive on Jan 8, 1957, and that death occurred at 11:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Wallace Olmenstein M.D. ADDRESS (Street, city or town, state) Cecilton, Md. DATE SIGNED 10 Jan 57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 1/11/57
22c. NAME OF CEMETERY OR CREMATORY Cecilton Cem.
22d. LOCATION (City, town, or county) Cecilton (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Edward Fullmer ADDRESS Millington, Md.
24a. REC'D BY REGISTRAR DATE JAN 14 1957
24b. REGISTRAR'S SIGNATURE Mrs. Ralph H. Reese

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00516

498 CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: CECIL

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: LIFE

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21 ELKTON

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: DEVINE HAVEN HOME

d. STREET ADDRESS: 1222 E. MAIN ST.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ISABELLE Middle Last JAMAR

4. DATE OF DEATH: Month JANUARY Day 15 Year 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 17, 1876

9. AGE (In years last birthday): 80 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WORK

10b. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN H. JAMAR MD

14. MOTHER'S MAIDEN NAME: MARGARET HOLLINGSWORTH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: MARY H. JAMAR Address: ELKTON, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral Hemorrhage	4 hours
DUE TO (b)	Cardio vascular renal	10 years
DUE TO (c)	Arterio sclerosis	10 days

442X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19 30, to Jan 15, 19 57 that I last saw the deceased alive on Jan 15, 19 57, and that death occurred at 6:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Herbert Bates M.D. — ADDRESS (Street, city or town, state): Elkton md — DATE SIGNED

PHYSICIAN'S NAME (Type): J. HERBERT BATES

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: JAN. 18, 1957

22c. NAME OF CEMETERY OR CREMATORY: PRESBYTERIAN

22d. LOCATION (City, town, or county) (State): ELKTON, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: W. Henry Pepper ADDRESS: ELKTON, Md.

24a. REC'D BY REGISTRAR DATE: 1/19/57

24b. REGISTRAR'S SIGNATURE: E R Frazer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

RECEIVED

JAN 22 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00517

499 CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Elkton
d. STREET ADDRESS: R. F. D. # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sofia — Middle: M. — Last: Jensen

4. DATE OF DEATH: Month: January — Day: 23 — Year: 1957

5. SEX: F

6. COLOR OR RACE: Wh.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 6, 1873

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10b. KIND OF BUSINESS OR INDUSTRY: House Work

11. BIRTHPLACE (State or foreign country): Denmark

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Michael Pedersen

14. MOTHER'S MAIDEN NAME: No Information

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Paul Jensen, Address R. F. D. # 1 Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days

442X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cardio vascular renal — 10 years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19 57, to Jan 23, 19 57, that I last saw the deceased alive on Jan 23, 19 57, and that death occurred at 4:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J Herbert Bates M.D. — ADDRESS (Street, city or town, state): Elkton Md — DATE SIGNED: Jan 24. 57

PHYSICIAN'S NAME (Type): J. HERBERT BATES

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Jan. 27, 1957

22c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery

22d. LOCATION (City, town, or county) (State): Elkton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Henry Giffin — ADDRESS: 207 E. Main St. Elkton Md.

24a. REC'D BY REGISTRAR DATE: 1/30/57

24b. REGISTRAR'S SIGNATURE: F R Frazer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

531 CERTIFICATE OF DEATH

Reg. Dist. No. 00518

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
c. LENGTH OF STAY IN 1b: 35 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Harris — Last: Johnson

4. DATE OF DEATH: Month: January — Day: 24 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept 28 1896

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: U.G.Government

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John M.Johnson

14. MOTHER'S MAIDEN NAME: Selma Tyson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W W 1

16. SOCIAL SECURITY NO.: 218-05-0826

17. INFORMANT: Mrs John H.Johnson — Address: North East, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pericarditis — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO
(b): Coronary Thrombosis — 1 Hr.

DUE TO
(c): Coronary Atherosclerosis — 7

4201

Conditions, if ony, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Duodenal Ulcer. Epilepsy.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 20 Jan, 1957, to 24 Jan, 1957, that I last saw the deceased alive on 24 Jan, 1957, and that death occurred at 8:45 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Klaus H. Huebner M.D. — ADDRESS (Street, city or town, state): North East, Md — DATE SIGNED: 25 Jan '57

PHYSICIAN'S NAME (Type): Klaus H. Huebner M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Jan 27, 1957

22c. NAME OF CEMETERY OR CREMATORY: Methodist

22d. LOCATION (City, town, or county) (State): North East Cecil, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R. Grant — ADDRESS: North East, Maryland

24a. REC'D BY REGISTRAR DATE: 1-25-57

24b. REGISTRAR'S SIGNATURE: Sarah E. Rothermel

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00519

532 **CERTIFICATE OF DEATH**

Reg. Dist. No. 92

1. PLACE OF DEATH
a. COUNTY Cecil — Elkton — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ~~Chesapeake City R, D 1~~

c. LENGTH OF STAY IN 1b ~~1 Yr.~~

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Near Chesapeake City, Md. XO

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital

d. STREET ADDRESS Ches. City RD1.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐ 1

3. NAME OF DECEASED (Type or print) First Maude Middle Hollier Last Johnson

4. DATE OF DEATH Month Jan. Day 5 ~~57~~ Year 19 57

5. SEX F.

6. COLOR OR RACE Wh,

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH Nov. 7, 1883

9. AGE (In years last birthday) 73 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher

10b. KIND OF BUSINESS OR INDUSTRY Retired

11. BIRTHPLACE (State or foreign country) Mass.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Charles H. Hollier

14. MOTHER'S MAIDEN NAME Jennie Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT Address R D. 1 Md.
A. Hallier Johnson Chesapeake City

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 2 days

443 ×

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Hypertension C.V. Disease — 4 years

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 260 × Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1956, to Jan 5, 1957, that I last saw the deceased alive on Jan 4, 1957, and that death occurred at 12:55 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE Henry Davis M.D. ADDRESS (Street, city or town, state) Chesapeake City, Md DATE SIGNED

PHYSICIAN'S NAME (Type) HENRY V. DAVIS

22a. BURIAL, CREMATION, REMOVAL (Specify) Removal

22b. DATE THEREOF Jan 5/57

22c. NAME OF CEMETERY OR CREMATORY Hopedale Cemt

22d. LOCATION (City, town, or county) (State) Hopedale, Mass

23. FUNERAL DIRECTOR'S SIGNATURE [illegible] ADDRESS Elkton, Md

24a. REC'D BY REGISTRAR DATE Jan 7

24b. REGISTRAR'S SIGNATURE H B Frazer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

533

CERTIFICATE OF DEATH

00520 96
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point, Maryland
c. LENGTH OF STAY IN 1b: 30 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New Jersey — b. COUNTY: Cape May
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Villas 67x-3
d. STREET ADDRESS: 6 E. Florida Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward — Middle: M. — Last: Kropp

4. DATE OF DEATH: Month: 1 — Day: 26 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-20-96

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bartender

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Philadelphia, Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Kropp

14. MOTHER'S MAIDEN NAME: Esther Moore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 209 14 3685

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia, unresolved, left lung. — INTERVAL BETWEEN ONSET AND DEATH: 6 - 7 days
DUE TO
223x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cyst of brain, right, cause unknown-involving — Unknown
DUE TO
(c): posterior frontal & anterior parietal lobes.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis, generalized, severe.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that VA attended the deceased from 12-27- 1956 to 1-26- 1957 [illegible], and that death occurred at 12-Noon, from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph C. Grasberger M.D. — ADDRESS (Street, city or town, state): VAH., Perry Point, Md. — DATE SIGNED: 1-26-57

PHYSICIAN'S NAME (Type): JOSEPH C. GRASBERGER, M.D., Acting Dir ector, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
22b. DATE THEREOF: 1-28-57
22c. NAME OF CEMETERY OR CREMATORY: Beverly National
22d. LOCATION (City, town, or county) (State): Beverly, New Jersey

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: C. H. Iredell Funeral Home, Haddon Heights N.J. C. H. IREDELL FUNERAL HOME, Haddon Heights, N.J.

24a. REC'D BY REGISTRAR DATE: 1-27-57

24b. REGISTRAR'S SIGNATURE: Irene E. Daugherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

500

CERTIFICATE OF DEATH

00521 Reg. Dist. No. 92

1. PLACE OF DEATH
a. COUNTY: Cecil
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: 134 W. High St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Howard; Middle; Last Lewis

4. DATE OF DEATH: Month January; Day 8; Year 1957

5. SEX: M

6. COLOR OR RACE: Wh.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 12, 1877

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Post Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Aberdeen Proving Grounds

11. BIRTHPLACE (State or foreign country): Elkton, Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Charles E. Lewis

14. MOTHER'S MAIDEN NAME: Martha Maxwell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 197-10-0527

17. INFORMANT: Miss Carrie Lewis
Address: 134 W. High St. Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the pancreas — INTERVAL BETWEEN ONSET AND DEATH: 3 months
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 157X
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 1, 1956 to Jan. 8, 1957, that I last saw the deceased alive on Jan. 8, 1957, and that death occurred at 8:20 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Ralph Andrews, Jr. M.D.
ADDRESS (Street, city or town, state): 233 E. Main St.
DATE SIGNED: 1/8/57
PHYSICIAN'S NAME (Type): S. RALPH ANDREWS, JR. M.D. Elkton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-11-1957
22c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery
22d. LOCATION (City, town, or county) (State): Elkton Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Kenney Tyson ADDRESS: Elkton, Md.
24a. RECD BY REGISTRAR DATE: JAN 14 1957
24b. REGISTRAR'S SIGNATURE: L. R. Frazer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

501

00522

Reg. Dist. No.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Items 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: —
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X O E lkton R D 1
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Boy — Last: Little

4. DATE OF DEATH: Month: January — Day: 28 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan 28 - 1957

9. AGE (In years last birthday) yrs.:

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: 2 Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: Herbert F. Little — Md

14. MOTHER'S MAIDEN NAME: Patrica Bower. Va.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Herbert F. Little — Address: Elkton RD. 1 Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Anoxia due to strangulation of
DUE TO: Umbilical cord
761.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: 2 hours — 5 minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 28, 1957, to Jan 28, 1957, that I last saw the deceased alive on Jan. 28, 1957, and that death occurred at 7:50 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Ralph Andrews Jr. M.D.
ADDRESS (Street, city or town, state): 233 E. Main St.
DATE SIGNED: 1/28/57
PHYSICIAN'S NAME (Type): S. RALPH ANDREWS JR M.D. Elkton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan 29, 1957
22c. NAME OF CEMETERY OR CREMATORY: Methodist
22d. LOCATION (City, town, or county) (State): North East Cecil Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant
ADDRESS: North East

24a. REC'D BY REGISTRAR DATE: 1/29/57
24b. REGISTRAR'S SIGNATURE: H R Frazer

2017192X46

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01726

502

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 3½ hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East - rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Rebecca; Middle: Jane; Last: Lockard

4. DATE OF DEATH: Month: January; Day: 7; Year: 19 57

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 1, 1955

9. AGE (In years last birthday): 1 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Howard E. Lockard, Sr.

14. MOTHER'S MAIDEN NAME: Helen Tester

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): -
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Howard E. Lockard — Address: North East, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Meningitis due to Typ B Hr. Influza.
DUE TO
(b):
DUE TO
(c):

340.0

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

INTERVAL BETWEEN ONSET AND DEATH: 4 Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 5, 19 57, to Jan. 7, 1957, that I last saw the deceased alive on Jan. 7, 19 57, and that death occurred at 6 P.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Ralph Andrews, Jr. M.D.

ADDRESS (Street, city or town, state): 233 E. Main St., Elkton, Md.

DATE SIGNED: 1/9/57

PHYSICIAN'S NAME (Type): S. Ralph Andrews, Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-10-1957

22c. NAME OF CEMETERY OR CREMATORY: Methodist

22d. LOCATION (City, town, or county) (State): North East, Cecil Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph Grant

ADDRESS: North East, Md.

24a. REC'D BY REGISTRAR DATE: 1/10/57

24b. REGISTRAR'S SIGNATURE: E R Fraze

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corbon papers. Pages 1 and 2 should be filed with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00523

534

Reg. Dist. No. 94

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East Rural
c. LENGTH OF STAY IN 1b: All life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William Middle: Miller Last: Lum
4. DATE OF DEATH: Month: 1-12 Day: Year: 19 57

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12-6-1888
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ship Wright
10b. KIND OF BUSINESS OR INDUSTRY: Building ships
11. BIRTHPLACE (State or foreign country): Cecil County, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Lum
14. MOTHER'S MAIDEN NAME: Hannah Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 221-01-8421
17. INFORMANT Address: Ellen Lum, North East, Rural, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH:

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: A. LeDodson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 1-12-57

EXAMINER'S NAME (Type): R.C.Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-15-1957
22c. NAME OF CEMETERY OR CREMATORY: St Augustine
22d. LOCATION (City, town, or county) (State): Chesapeake City RD Md

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant ADDRESS: North East, Md
24a. REC'D BY REGISTRAR DATE: 1-15-57
24b. REGISTRAR'S SIGNATURE: Sarah E. Rothermel

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00524

503

CERTIFICATE OF DEATH

Reg. Dist. No. 9r

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: UNION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HACKS POINT, MD. EARLEVILLE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MABLE — Middle A. — Last MAY

4. DATE OF DEATH: Month JAN. — Day 28 — Year 19 57

5. SEX: Female
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: FEB. 20, 1894
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ABRAHAM ALLEN
14. MOTHER'S MAIDEN NAME: SALLIE JOHNSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 216-20-8430
17. INFORMANT: EDWARD MAY — Address: HACKS POINT, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Sigmoid Fistula — INTERVAL BETWEEN ONSET AND DEATH: 6 weeks
153X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Operation for Ridney stones left Ridney — 3 mos
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bilateral staghorn calculi both Kidneys for years.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct, 1956, to Jan 28, 1957, that I last saw the deceased alive on 7:45 a.m. Jan 28 19 57, and that death occurred at 7:45 a.m. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wallace Obenshain M.D. — ADDRESS (Street, city or town, state): Cecilton, md. — DATE SIGNED: 1-30-57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 1/31/57
22c. NAME OF CEMETERY OR CREMATORY: JOHNTOWN CEM.
22d. LOCATION (City, town, or county) (State): RURAL EARLEVILLE MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Hellows — ADDRESS: Millington Md.
24a. REC'D BY REGISTRAR (DATE): FEB 1 1957
24b. REGISTRAR'S SIGNATURE: E. R. Frazer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

535 Reg. Dist. No. 00525

1. PLACE OF DEATH
a. COUNTY: Cecil
b. STATE: Maryland MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 7 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
d. STREET ADDRESS: 1089 Ave. A.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles Middle Elmer Last McCommons

4. DATE OF DEATH: Month 1/4 Day 57 Year 19

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4/23/1867

9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: C.P. Tel. Co.

11. BIRTHPLACE (State or foreign country): Hanford Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John McCommons

14. MOTHER'S MAIDEN NAME: Phebe Clifton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Mrs. Geo. G Lynch Address: Perry Point Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Carcinoma Prostate
DUE TO (c): ___

177x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5-3, 19 56 to 1-3, 19 57, that I last saw the deceased alive on 1-3, 19 57, and that death occurred at 3 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: O. L. Lewis MD M.D.
ADDRESS (Street, city or town, state)
DATE SIGNED

PHYSICIAN'S NAME (Type) ___

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/6/57

22c. NAME OF CEMETERY OR CREMATORY: Deer Creek

22d. LOCATION (City, town, or county) (State): Hanford Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Langston & Son Havre de Grace Md. ADDRESS

24a. REC'D BY REGISTRAR DATE 1/5/57

24b. REGISTRAR'S SIGNATURE: Irene E. Daugherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed as required in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

536

Reg. Dist. No. 00526 90

1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD. b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Cecilton
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Stanley Middle S. Last Mc Cubbin
4. DATE OF DEATH Month Jan. Day 14 Year 1957
5. SEX M.
6. COLOR OR RACE W.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Aug. 13, 1882
9. AGE (In years last birthday) 74 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer Store
10b. KIND OF BUSINESS OR INDUSTRY Store
11. BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Fletcher Mc Cubbin
14. MOTHER'S MAIDEN NAME Mary Hunt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-34-2132
17. INFORMANT Address Mrs. Emma Mc Cubbin Cecilton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 72 hours.
332 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cerebral Arteriosclerosis — years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bed fast for 1 year - tube fed - 1 year
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 1956, to Jan, 1957, that I last saw the deceased alive on Jan 14, 1957, and that death occurred at 8 3/4 a M, from the causes and on the date stated above.
ACTUAL SIGNATURE Wallace Obenshain M.D. ADDRESS (Street, city or town, state) Cecilton, Md DATE SIGNED 14 Jan 57
PHYSICIAN'S NAME (Type) Wallace Obenshain Cecilton, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 1/17/57
22c. NAME OF CEMETERY OR CREMATORY Cecilton Cem.
22d. LOCATION (City, town, or county) Cecilton (State) MD.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows ADDRESS Millington Md
24a. REC'D BY REGISTRAR DATE
24b. REGISTRAR'S SIGNATURE Mrs. Ralph Reese

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

504

CERTIFICATE OF DEATH

Reg. Dist. No. 00527 52

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 2 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Rising Sun
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emma — Middle: Wilson — Last: McNamee

4. DATE OF DEATH: Month: Jan. — Day: 28 — Year: 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 9, 1876

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Rising Sun, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Charles Wilson

14. MOTHER'S MAIDEN NAME: Elizabeth Fisher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: William McNamee — Address: Rising Sun, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Accident
331X
DUE TO
(b): Arteriosclerosis
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: White at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-26-57, 19__, to 1-28, 19 57, that I last saw the deceased alive on 1-28-, 19 57, and that death occurred at 1-30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R.C. Dodson, M.D.
ADDRESS (Street, city or town, state): Rising Sun, Md.
DATE SIGNED: 1-29-57

PHYSICIAN'S NAME (Type): R.C.Dodson — Rising Sun, Cecil Co. Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 1, 1957
22c. NAME OF CEMETERY OR CREMATORY: Brookview
22d. LOCATION (City, town, or county) (State): Rising Sun Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Tyson
ADDRESS: Rising Sun, Md.

24a. REC'D BY REGISTRAR DATE: 1/31/57
24b. REGISTRAR'S SIGNATURE: F R Fraze

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed as required in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00528

537

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 3 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 47x3 Washington,
d. STREET ADDRESS: 3317 Holmead Pl., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSEPH — Middle — Last MELTON

4. DATE OF DEATH: Month January — Day 5 — Year 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 26, 1934

9. AGE (In years last birthday): 22 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Marshall Melton Ruffing

14. MOTHER'S MAIDEN NAME: Hannah Melton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): Korean

16. SOCIAL SECURITY NO.: 579-48-0568

17. INFORMANT — Address: Hospital Records, VAH., Perry Point, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ventricular Fibrillation due to unknown cause, — INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
(b) Edema, pulmonary, bilateral, severe — 24 hours
DUE TO
(c) Excision of Surgery - Pilonidal cyst (Post-operative) Date of operation — 1-3-57

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that VA attended the deceased from January 2, 1957, to January 5, 1957, that I last saw the deceased alive on [redacted] and that death occurred at 12:55 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Oppler M.D. — ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md. — DATE SIGNED: 1-7-57

PHYSICIAN'S NAME (Type): W. OPPLER — Director, Professional Services.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 1-7-57

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county) (State): Ft. Myer, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Pennington & Son, Havre DeGrace, Md.

24a. REC'D BY REGISTRAR DATE: Jan 9-57

24b. REGISTRAR'S SIGNATURE: Irene E. Dougherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Items 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00529

538

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point

c. LENGTH OF STAY IN 1b: 11 mo. 18 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3 V01-4

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

d. STREET ADDRESS: 3308 N. Calvert

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES — Middle D. — Last MILLER

4. DATE OF DEATH: Month January — Day 21 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-2-90

9. AGE (In years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: unknown

11. BIRTHPLACE (State or foreign country): Nebraska

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William H. Miller - Deceased

14. MOTHER'S MAIDEN NAME: Myrtle M. Roberts - Deceased

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 215-03-1714

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchogenic carcinoma of right lung with re-
DUE TO: currence into right pleural cavity and hilar
(b): lymph nodes
DUE TO:
(c):

162 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis general severe - unknown. Absence of the right lung acquired 3-21-56.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — Month, Day, Year — a. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that VA attended the deceased from February 3, 1956, to January 21, 1957, that I last saw the deceased ~~alive on~~ ~~19~~, and that death occurred at 5:20 a.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Oppler M.D.

ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md.

DATE SIGNED: 1-21-57

PHYSICIAN'S NAME (Type): W. OPPLER

Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): removal

22b. DATE THEREOF: 1-21-57

22c. NAME OF CEMETERY OR CREMATORY: unknown

22d. LOCATION (City, town, or county) (State): Gerardstown, West Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son

ADDRESS: Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: 1-21-57

24b. REGISTRAR'S SIGNATURE: Irene E. Doughty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

539

00530

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit
c. LENGTH OF STAY IN 1b: 2 Hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Rowlandville
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dean Middle: Last: Moore

4. DATE OF DEATH: Month: Jan. Day: 15 Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 12, 1886

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cashier

10b. KIND OF BUSINESS OR INDUSTRY: Bank

11. BIRTHPLACE (State or foreign country): Philadelphia, Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: John W. Moore

14. MOTHER'S MAIDEN NAME: Ellen Parsons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 216-05-8164

17. INFORMANT: Mrs. Dean Moore Address: Rowlandville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Unknown
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertheprodesim

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1, 1955, to Jan 14, 1957, that I last saw the deceased alive on Jan 14, 1957, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Dudley Phillips M.D. ADDRESS (Street, city or town, state): Darlington Md DATE SIGNED: 1/17/57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Jan. 19, 1957

22c. NAME OF CEMETERY OR CREMATORY: West Nottingham

22d. LOCATION (City, town, or county) (State): Near Colora Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J. Earl Tyson, Rising Sun, Md.

24c. REC'D BY REGISTRAR DATE: Jan 17-16

24b. REGISTRAR'S SIGNATURE: L M Worthington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

505 — Reg. Dist. No. 00531

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 4 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Cowantown, Elkton. Md. R.D.
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Dale — Middle: A — Last: Poarch
4. DATE OF DEATH: Month: 1 — Day: 31 — Year: 1957
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Sept. 27 1950
9. AGE (In years last birthday): 6 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b. KIND OF BUSINESS OR INDUSTRY: School Boy
11. BIRTHPLACE (State or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Arvis S. Poarch
14. MOTHER'S MAIDEN NAME: Helen Skompski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: ------
17. INFORMANT — Address: Arvis S. Poarch, Elkton, R.D.4 Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Perforating wound of chest left side at — INTERVAL BETWEEN ONSET AND DEATH:
919.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) 10 interspacegoing through diaphragm left kidney, colon and head of pancreas and came out 3 inches above pelvis
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Was shot by 22 caliber Rifle
20c. TIME OF INJURY: Hour: a.m. 3.30 p.m. — Month, Day, Year: 1-31-57
20d. INJURY OCCURRED: While at work [ ] Not while at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town): Elkton — (County): Cecil — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X] Inquiry [X], and find that death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: R.C. Dodson M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 2-1-57
EXAMINER'S NAME (Type): R.C. Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-3-57
22c. NAME OF CEMETERY OR CREMATORY: Gilpin Manor Mem. Pk.
22d. LOCATION (City, town, or county): Ekltpn Cecil — (State): Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Henry Tippen — ADDRESS: Elkton, Md.
24a. REC'D BY REGISTRAR — DATE: 2/6/57
24b. REGISTRAR'S SIGNATURE: J R Frazer

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00532
Reg. Dist. No.

540

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Colora
c. LENGTH OF STAY IN 1b: 5 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address):

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Colora
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Vernon Middle: Wilson Last: Preston
4. DATE OF DEATH: Month: 1 Day: 6 Year: 1957
5. SEX: M.
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-11-1903
9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Plumbing
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Jacob Preston
14. MOTHER'S MAIDEN NAME: Ella Gamble
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W.W.2
16. SOCIAL SECURITY NO.: 145-05-2617
17. INFORMANT Address: Mrs. ArthurNevitt, Haddonfidad, N.J.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH:
322.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Acute Alcoholism
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
420.1
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R deBordon M.D. — DATE SIGNED
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): R.C. Dodson — 1-8-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-10-57
22c. NAME OF CEMETERY OR CREMATORY: Oxford Cem.
22d. LOCATION (City, town, or county) (State): Oxford, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J. Earl Tyson Rising Sun, Md.
24a. REC'D BY REGISTRAR DATE: Jan 2-57
24b. REGISTRAR'S SIGNATURE: L M Worthington

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

541

CERTIFICATE OF DEATH

Reg. Dist. No. 96 — 00533

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 23yrs.6mo.21days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47x-3
d. STREET ADDRESS: 16th & Q. Streets, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HAZAR — Middle F. — Last PULATIN

4. DATE OF DEATH: Month January — Day 11 — Year 19 57

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-27-94
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Tennessee
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia, bilateral, lower lobes, — INTERVAL BETWEEN ONSET AND DEATH: 7-10 days
420.1
DUE TO: unresolved
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b) Coronary heart disease — unknown
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis, general, severe - unknown
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
VA

21. I certify that I attended the deceased from June 21, 19 33, to January 11, 19 57, that I last saw the deceased alive on [illegible], and that death occurred at 11:15 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Oppler — M.D.
ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md.
DATE SIGNED: 1-14-57
PHYSICIAN'S NAME (Type): W. OPPLER
Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 1-14-57
22c. NAME OF CEMETERY OR CREMATORY: Baltimore National
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Pennington & Son, Havre de Grace, Md.
24a. RECD BY REGISTRAR DATE: Jan 17-57
24b. REGISTRAR'S SIGNATURE: Irene E. Daugherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed as to items 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers.

VS A15 (4)
15M 9/55

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. Bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

506 CERTIFICATE OF DEATH

00534

Reg. Dist. No. 92

1. PLACE OF DEATH

COUNTY: Cecil — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton

LENGTH OF STAY (in this place): one week

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Devine Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland — COUNTY: Cecil

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton

STREET ADDRESS (If rural give location): 428 North Street

3. NAME OF DECEASED (Type or Print): (First) M (Middle) Virginia (Last) Reed.

4. DATE OF DEATH: (Month) Jan (Day) 10 (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Single	86yrs	86 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework		Maryland	U.S.A.

13. FATHER'S NAME: William Reed

14. MOTHER'S MAIDEN NAME: Margaret Ferguson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
		Miss Ada Reed, 428 North St., Elkton, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

782.4 IMMEDIATE CAUSE (A) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: Jan. 7, 1957

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 29, 1956, to Jan. 10, 1957, that I last saw the deceased alive on Jan. 10, 1957, and that death occurred at 11:20 M, from the causes and on the date stated above.

SIGNATURE D. Ford Sprecher M.D. — **ADDRESS** (Street, city, town, state) Elkton, Md. — **DATE SIGNED** Jan. 11, 1957

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1-13-57	Bayview Methodist Cemetery	Bayview, Cecil Co. Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
Jan 11, 1957	H R Frazer	Joseph R Grant	North East, Md.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, [redacted]3 should be detached for use as the burial-transit permit. Then please remove carbon papers. [redacted]es 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

542

CERTIFICATE OF DEATH

00535
Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point, Md.
c. LENGTH OF STAY IN 1b: 1yr.3mo.18days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sugar Grove
d. STREET ADDRESS: 83x-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ROBERT — Middle K. — Last REEVES

4. DATE OF DEATH: Month January — Day 7 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-25-07

9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dispatcher

10b. KIND OF BUSINESS OR INDUSTRY: Cab Company

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lundy Reeves

14. MOTHER'S MAIDEN NAME: Mary Pickett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 229 14 5313

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial fibrosis interventricular septum — INTERVAL BETWEEN ONSET AND DEATH: unknown
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic coronary heart disease, severe — unknown
DUE TO
(c) Arteriosclerosis, general — unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary edema and congestion - 48 hrs.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

VA

21. I certify that I attended the deceased from September 20, 1955, to January 7, 1957, [illegible] saw the deceased on [illegible] and that death occurred at 11:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Oppler, M.D. — ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md. — DATE SIGNED: 1-8-57

PHYSICIAN'S NAME (Type): W. OPPLER — Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 1-8-57
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Pennington & Son, Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: 1-11-57

24b. REGISTRAR'S SIGNATURE: Irene E. Dougherty

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

507 CERTIFICATE OF DEATH

00536

Reg. Dist. No. 97

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 14x12 Kennedyville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Harry ~~Scotten~~ — Middle: Scotten — Last: ~~Harry~~

4. DATE OF DEATH: Month: January — Day: 10 — Year: 1957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4/26/82

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer (retired)

10b. KIND OF BUSINESS OR INDUSTRY: owner

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown John Scotten

14. MOTHER'S MAIDEN NAME: Unknown Sarah E. Greenwood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Robert Sutton — Address: Kennedyville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
332x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Dehydration and cerebral arteriosclerosis — years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 151x Carcinoma of Stomach

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1, 1957, to Jan 10, 1957, that I last saw the deceased alive on Jan 10, 1957, and that death occurred at 1¼a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wallace Obenshain M.D. — ADDRESS (Street, city or town, state): Cecilton, Md — DATE SIGNED: 10 Jan 57

PHYSICIAN'S NAME (Type): Wallace Obenshain, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/13/57

22c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery

22d. LOCATION (City, town, or county) (State): Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J Willis Wells — ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: JAN 14 1957

24b. REGISTRAR'S SIGNATURE: F. R. Frazer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed as to items 1 and 2 should be filed in by the funeral director, [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

508

Reg. Dist. No. 00537

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: R. D 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby — Middle: — Last: Simmonds

4. DATE OF DEATH: Month: JANUARY — Day: 18 — Year: 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/18/57

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR — Months: — Days: — IF UNDER 24 HRS. — Hours: — Min.: 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Allery

14. MOTHER'S MAIDEN NAME: Barbara Simmonds

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mother — Address: Elkton RD 1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Premature Birth — 5½ hours
DUE TO
776X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/18, 1957, to 1/18, 1957, that I last saw the deceased alive on 1/18, 1957, and that death occurred at 1:03 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James L Johnson M.D. — ADDRESS (Street, city or town, state): 275 E. High St, Elkton, Md. — DATE SIGNED:

PHYSICIAN'S NAME (Type): James L. Johnson MD — 275 E. High St, Elkton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Jan. 19, 1957

22c. NAME OF CEMETERY OR CREMATORY: Cherry Hill Meth Cem

22d. LOCATION (City, town, or county): Cecil County (State): Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks — ADDRESS: 103 Stockton St. Elkton, Md.

24a. REC'D BY REGISTRAR DATE: 1/19/57

24b. REGISTRAR'S SIGNATURE: F R Frazer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Items 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00538

543 # CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH	**2. USUAL RESIDENCE (HOME) OF DECEASED**
COUNTY Cecil — MARYLAND	STATE Maryland — COUNTY Cecil
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlestown — LENGTH OF STAY (in this place) 5 weeks	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Stanley	M	Smith	Jan	13	1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	Oct. 21, 1878	78 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Farmer owner	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
J. Starrett Smith	Emma Louise Russell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No		214-20-8675	Mrs. Harold Shea, North East, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 IMMEDIATE CAUSE (A) HEART ARREST — 6 MIN

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) GENERALIZED ARTERIOSCLEROSIS, ESP. CORONARY — 10 years
DUE TO (C) OLD AGE

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. KIDNEY DAMAGE, CHRONIC PYELONEPHRITIS

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from NOV 4, 1956, to JAN 13, 1957, that I last saw the deceased alive on JAN 13, 1957, and that death occurred at 2.50 a m M, from the causes and on the date stated above.

SIGNATURE	M.D.	ADDRESS (Street, city, town, state)	DATE SIGNED
Otto Vogel		CECIL AVE, NE.	1-15-57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 16, 1957	Rosebank Cemetery	Calvert Maryland

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
1-16-57	Sarah E. Rothermel	Joseph R Grant	North East, Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

509

CERTIFICATE OF DEATH

00539

Reg. Dist. No. 92

1. PLACE OF DEATH
a. COUNTY: Cecil
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 North East
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Maggie Middle: M Last: Stewart

4. DATE OF DEATH: Month: January Day: 23 Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 1 1876

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Isaiah Biddle

14. MOTHER'S MAIDEN NAME: Kate Pierce

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Harold T. Stewart
Address: Harold T. Stewart North East, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Rt. Cerebral Thrombosis with left Hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
442X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertensive Cardiovascular Renal Disease — 10 yrs.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 260X Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 20 Jan, 1957, to 23 Jan, 1957, that I last saw the deceased alive on 23 Jan, 1957, and that death occurred at 10:24 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Klaus H. Huebner M.D.
ADDRESS (Street, city or town, state): North East Rd
DATE SIGNED: 25 Jan '57

PHYSICIAN'S NAME (Type): Klaus H. Huebner M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Jan 26, 57

22c. NAME OF CEMETERY OR CREMATORY: Methodist

22d. LOCATION (City, town, or county) (State): North East, Cecil, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant
ADDRESS: North East, Maryland

24a. REC'D BY REGISTRAR DATE: 1/25/57

24b. REGISTRAR'S SIGNATURE: H Bragg

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00540

Reg. Dist. No. 541

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun
c. LENGTH OF STAY IN 1b: All life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cherry St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Rising Sun
d. STREET ADDRESS: Cherry St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emily — Middle: Duyckinck — Last: Ward

4. DATE OF DEATH: Month: Jan. — Day: 9 — Year: 19 57

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒x DIVORCED ☐

8. DATE OF BIRTH: 12-25-1882

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Cecil Co. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Aaron Longstreet Duyckinck

14. MOTHER'S MAIDEN NAME: Williamina Ward Read

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: Williamina Ward, Rising Sun, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

592x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Chronic Nephritis.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 420.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.L. Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒x — DATE SIGNED: 1-10-58

EXAMINER'S NAME (Type): R.C. Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-14-57

22c. NAME OF CEMETERY OR CREMATORY: West Nottingham Cem.

22d. LOCATION (City, town, or county) (State): Colora, Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: J. Earl Tyson Rising Sun Md.

24a. REC'D BY REGISTRAR: Jan 10 - 57

24b. REGISTRAR'S SIGNATURE: Lem Worthington

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5,6,7 FilmG209 1-11-57 et

00541

CERTIFICATE OF DEATH

515

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-- Sylmar
c. LENGTH OF STAY IN 1b: 38 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rual - Rising Sun
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: William — Middle: H — Last: Witman

4. DATE OF DEATH: Month: January — Day: 5 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: May 2, 1881

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Penn.

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: William Witman

14. MOTHER'S MAIDEN NAME: Emma Steffy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Lidie Witman — Address: Rising Sun, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ruptured esophageal varices — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
581.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cirrhosis of liver — 2 yrs.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10 1 19 56 to 1 5 19 57, that I last saw the deceased alive on 1 14 19 57, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Neil Taylor M.D. — ADDRESS (Street, city or town, state): Rising Sun, Md. — DATE SIGNED: 1/5/57

PHYSICIAN'S NAME (Type): Neil R Taylor Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/8/1957

22c. NAME OF CEMETERY OR CREMATORY: Brookview

22d. LOCATION (City, town, or county) (State): Rising Sun, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph M Reed — ADDRESS: Rising Sun, Md

24a. REC'D BY REGISTRAR (DATE): Jan 8 57

24b. REGISTRAR'S SIGNATURE: Lemuel Mangington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, it should be detached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55